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ABSTRACT

This paper discusses the discrimination against individuals with psychiatric disabilities in educational institutions and how the transition from discrimination to acceptance is occurring. It examines the characteristics of those who return to educational institutions, why they return, and the specific needs of individuals with psychiatric disabilities. The paper explores some of the myths and realities about people with mental illness and discusses how adult educators can assist and support people with mental illness in successfully achieving their educational goals. Quotations from students with mental disorders illustrate what it means to them to participate in an educational process. Two responses to the paper are attached and include positive remarks as well as criticisms, including the criticism that the focus of the paper on discrimination in postsecondary institutions does not discuss the acceptance of individuals with mental disorders in adult basic education programs. Overhead information summary sheets are also attached. (Contains 11 references.) (CR)

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FROM DISCRIMINATION TO ACCEPTANCE: SERVING PEOPLE WITH PSYCHIATRIC DISABILITIES IN ADULT EDUCATION

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By Karen V. Unger

Introduction

Until the early eighties it was not considered realistic for people with mental illness to fully participate in community life. At that time the movement to get people out of psychiatric hospitals was in full swing and although people with mental illness were moved into the community, there were few services to help them live a normal life. They certainly were not encouraged to better themselves through education so they could find jobs appropriate to their desires and abilities. In fact, if people with mental illness did go to school, and their presence was discovered, they were often given a psychiatric withdrawal "for their own good."

Over time, this situation has changed. Educational institutions were found guilty of discrimination based on a disability; more people with mental illness began returning to school; and the institutions gained more experience working with people with mental illness. This paper will discuss how the transition from discrimination to acceptance is occurring. It will examine characteristics of those who return to educational institutions, why they return and what their specific needs are. It will explore some myths and realities about people with mental illness. It will discuss how adult educators can assist and support them to be successful in achieving their educational goals. Finally, it will show, through a series of quotes, what it means to the students themselves to participate in an educational process.

From Discrimination to Acceptance

A recent report from the Centers for Disease Control and Prevention (Barker et al., 1992) reports that approximately 3.3 million adults have mental disorders that seriously interfere with one or more aspects of their daily life. Of those 3.3 million, about 2.6 million are currently limited in one or more functional areas. The employment rate for people with mental illness is about 20 to 25 percent. Among those with the most severe disabilities, the employment rate drops to about 15 percent (Anthony & Blanch, 1987). As more is learned about rehabilitation for people with mental illness, programs are developed that meet those rehabilitation needs, and attitudes are changed, those employment statistics are slowly changing.

One factor that has contributed to the perceived change in the percentage of people employed is the number of people with mental illness who are returning to college, working during school and then going on to jobs in their chosen field. Although no comprehensive study has been completed

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which documents this shift, several outcome studies from various programs support it (Unger, Anthony, Sciarappa & Rogers, 1991; Unger, 1993; Partons, 1993). Additionally, a study is in progress by this author through the University of Arizona to examine the long-term education and employment outcomes for people with psychiatric disabilities.

Another factor that has contributed to the movement from discrimination to acceptance was the development of a program at the Center for Psychiatric Rehabilitation at Boston University in 1981 (Unger, Danley, Hutchinson, Sullivan & Kohn, 1987). The program tested the feasibility of having people with mental illness return to the college campus to develop and implement career plans. The project demonstrated that students who participated in the program were more likely to continue with school, get jobs, be hospitalized less, and feel better about themselves than those who were participating in regular day treatment programs (Unger, Anthony, Sciarappa & Rogers, 1991). Because of the success of that project, a follow-up project to replicate the idea in other communities using only the resources within that community was developed. A number of programs at sites around the country successfully implemented supported education programs by redesigning existing programs, changing job descriptions and reallocating resources (Unger, 1993). Out of those projects came the idea of supported education (Unger, 1990).

Supported education is the process of helping people with a history of mental illness return to college by providing them with support and teaching them the skills they need to be successful on the college campus. It is very similar to the idea of the Ecology of Human Performance (Dunn, Brown & McGuigan, 1994). There is an assessment, planning and intervention process that looks at what kind of changes need to be made in the environment and/or the person through adaptation, alteration or accommodation.

The process of supported education has been utilized at postsecondary institutions and in mental health and rehabilitation programs throughout the country and is the topic of many articles and conference presentations. At many colleges and universities, people with psychiatric disabilities are now the second largest group receiving services from the offices of disabled students. Opportunities for education for people with psychiatric disabilities are now widely available. Programs are also beginning in Canada, Europe and Australia.

The Population of Students with Psychiatric Disabilities

The question is always raised, who are the people with mental illness who go back to school? In the studies conducted to date (Unger, 1993), a typical person who returns to school may be male or female, about 35 years of age and unmarried. About 85 percent of them will have spent an average of almost a year in the hospital, beginning about age 20. They will have been hospitalized about seven times. About 85 percent of them will be on

psychotropic medication. Their diagnoses are primarily schizophrenia, major depression and bipolar disorder. A few return to the hospital during the education process, but most do not. However, when they do, it is generally for a very limited time.

Because supported education students are returning to college, almost all are high school graduates. Many have tried to return to college on their own but were not successful in completing their course of study. Most receive social security benefits because of their disability, although about half are working. Close to 25 percent have a disability in addition to their psychiatric disability.

When students are asked what they believe are their functional limitations in an education environment, the majority name applying for financial aid and registration as major problems. Concentration, being distracted by internal and external stimuli, relating to others, taking tests, completing assignments on time, and managing time are other major problems.

Most students return to school to complete an AA or a BA degree. Others are working towards a vocational or technical certificate. Their retention rate is generally as good as other students, but their grades are often higher. Generally, people with psychiatric disabilities return to school for the same reasons we all do– to have more satisfying work that pays a higher salary.

Myths and Realities About People with Mental Illness

As people with mental illness continue to receive treatment in the community rather than having long term stays in a psychiatric hospital; as research continues on the most effective treatment for mental illness; and as new psychotropic medications are developed; our knowledge, attitudes and beliefs about mental illness are changing. Many things which we believed to be true in the past either are no longer true or our beliefs and misconceptions are being changed through increased knowledge and experience. Many myths are being dispelled.

Myth: When most of us think of people with psychiatric disabilities, the stigma of mental illness raises its ugly head. Images of homeless people, dirty and talking to themselves, or headlines about mass murders or bizarre crimes come to mind. Although these things do occasionally happen, they are so sensationalized that we tend to generalize the images to all people with mental illness. Reality: People with mental illness do not commit more crimes than the rest of the population (Monahan & Arnold, 1996). More frequently they are the victims of crimes because they are so vulnerable.

Myth: Traditionally, mental illness was seen as a chronic, lifelong disease. When entering the hospital for the first time, many people were told their lives were over and they should never expect to raise a family, complete school nor get a good job. Reality: A number of studies have shown that

most people (50 to 70 percent) recover from schizophrenia (Harding, 1996). New medications allow people with major depression or bi-poplar disorder to manage their illness sufficiently so they can lead relatively normal lives. Many who never expected to get out of the hospital are living successfully in the community. Few need prolonged hospital stays or intensive care for long periods of time. The treatment of choice is to stabilize the symptoms in the hospital through medication and then provide the necessary treatment in the community. Many people who receive rehabilitation and supportive services do not need to be on medication for the rest of their lives.

Myth: Traditionally, people with psychiatric disabilities are placed, either through the mental health or vocational rehabilitation system, in entry level or dead-end jobs. It was believed that they could not manage the stress of demanding work. Reality: Recent studies have shown that with proper training and support, people can work at jobs that are in their areas of interest (Drake et al, 1994). In other studies related to supported education, about half of the students are working and going to school. In the ongoing study at the University of Arizona, about one-quarter of the students are working in upper or middle management positions. Unfortunately, the average wage is only about six dollars per hour for most people. Due to the disincentives built into the Social Security system, many are also reluctant to work full-time and lose all their benefits.

Myth: Historically, many believed that the nature of mental illness, defined as thought and mood disorders, prevented people from learning. Reality: Several decades ago, teaching skills, such as independent living skills, gained popularity as a method of treatment. This demonstrated that, in fact, people with a mental illness could learn simple skills. This idea paved the way over time for the development of supported education. Although people with a mental illness may have greater difficulty with some learning, depending solely on the person's ability, symptoms and motivation, the learning problems usually do not prevent them from achieving their educational goals.

Myth: It was believed that people with mental illness would cause problems and disrupt the learning environment if they returned to school. Many school administrators were reluctant to have people with a known psychiatric disability on their campus. Reality: In a study done in the California community college system (Parton, 1993), students with a known psychiatric disability were not the students on campus causing the problems. This has been supported by many education programs around the country. However, the standard practice has become that should students with a mental illness cause problems on campus, they are responsible to the same code of student conduct that all students are and treated accordingly.

Myth: Many psychiatrists and mental health providers believed that going back to school would be too stressful for their clients. This attitude was shared by many potential students and their families. Reality: With proper

support and symptom management, people are able to take on the challenges of more meaningful activity. It is important that medications are monitored to compensate for the added activity and demand. Many psychiatrists have seen improvement in their patients as they start school and, consequently, decrease their medication dosage. This often results in a relapse as midterm comes around and students respond to the stress of papers due and exams. They may need more medication, rather than less, at this time.

Myth: Finally, many believed that students with a psychiatric disability would require more resources and time than other students with disabilities. Reality: It has been the experience of many programs that students do need more time initially to get registered, apply for financial aid and receive academic counseling. They may also need more personal support. However, the amount of time needed decreases as students get acclimated to the campus environment and develop a support network. Overall, they do not put a disproportionate drain on the resources.

Specific Needs of Students with Psychiatric Disabilities

Students with psychiatric disabilities are generally more alike than different from other students. However, some special considerations may be necessary as they are integrated into education programs.

Recruitment: Stigma remains the greatest barrier to recruitment. Many providers in the mental health system do not believe their clients capable of or ready to go back to school and do not make a referral or define school as a rehabilitation goal. This attitude is adopted by the clients themselves who may believe they are only able to be part of a day program where the greatest challenge is making lunch. Some education programs, because of their lack of experience with this population, may be wary of inviting them to participate. Other problems of recruitment are implied in the previously-discussed myths. What is needed is a fundamental belief, on the part of educators and the potential students themselves, that all people, regardless of their disability, are capable of learning and progressing.

Participation: Often, students with psychiatric disabilities are initially unsure of themselves in a school setting. Their attitudes are not unlike those of people who have been out of school for many years or who have English as a second language. Overcoming the initial anxieties occurs over a fairly brief period of time if the staff and the environment are open and friendly. However, continued personal support and encouragement may be needed throughout the early semesters as students learn to manage their symptoms and get back into a daily routine. Teaching learning and study skills as part of the curricula is often very helpful. Some postsecondary institutions provide a college preparatory or orientation class to review and strengthen student skills prior to official enrollment. These preparatory classes also help prospective students get accustomed to the campus, make

friends and formalize their educational goals. Staff can also assist the students with registration and obtaining financial aid during this time.

Retention: Students are retained through accommodations and support. Sensitive and appropriate accommodations make it possible for most students to remain in school. Many postsecondary institutions have developed peer support programs so people with common experiences can support each other. It is also helpful if staff are aware of changes in the students' behavior or demeanor. Referral to mental health or other community resources may be important if dramatic changes are noted. Many programs request the name of the students' mental health providers at intake and get permission to call them if there is a need. If students have to drop out for the semester for medical or psychiatric reasons, it is helpful if they can take incompletes and finish their work later, or complete the formal drop process so they do not accumulate failing grades on their transcripts, and thus, make it more difficult to return at a later date.

Accommodations

Accommodations for people with psychiatric disabilities are not particularly different from those with other disabilities. The most common accommodations are help with registration and financial aid. Extended time and a quiet place for testing, including permitting exams to be individually proctored, read orally, dictated or typed and increased frequency of exams may all be helpful. Changing test formats (e.g. from essays to multiple choice) is helpful for some. Using alternative forms for students to demonstrate course mastery (e.g. a narrative tape instead of a written diary), may be helpful to others. Giving a speech to the instructor rather than to the whole class and using a computer in class are other accommodations recommended, if needed.

Extended time for some written assignments may be necessary. Note takers, tape recorders and books on tape are also helpful. Some students require seating modifications if they are more comfortable by a door or window, at the back of the room rather than the front. Others require beverages in class because of the dry mouth caused by some medications. Some students may require parking accommodations. Many students find it helpful if there is a quiet place on campus where they can be by themselves or with their peers. It is helpful to many if there is someone they can check in with when they come onto the campus.

Sometimes accommodations are required in the course of study so the student can complete a degree program. The American Council on Education recommends providing modifications, substitutions or waivers of courses, major fields of study or degree requirements on a case-by-case basis. (Such accommodations need not be made if the institution can demonstrate the changes required would substantially alter essential elements of the course or program.) An example might be waiving a

language requirement that may not be critical to the mastery of the occupational skills implicit in the awarding of the degree.

Implications for the Adult Education Accommodations Model

The principles and values implicit in the adult education accommodations model are the same for working with students with psychiatric disabilities. There must be a willingness to take the students where they are, help them clarify and validate their experiences and needs, and provide the necessary services and accommodations while maintaining the program goals and standards.

Because of the unfamiliarity of many adult education staff with mental illness, it may be helpful to ask the following questions when providing services:

1. How would I solve this problem if the person had a physical disability?
2. What reasonable accommodations are needed?
3. Is this an academic or a treatment problem?
4. Do I need to make a referral to a community or campus resource?
5. Has there been a violation of the student code of conduct?
6. Am I working harder on the problem than the student who presented the problem? (Unger, 1991).

It might also be helpful for staff to learn simple techniques for helping students manage their anxieties. Two examples may be instructive. If students are extremely anxious, they may need a quiet place such as a study carrel to decompress. Earphones with quiet music might be helpful. If students appear to be in a panic, it is important that staff maintain their own self-control, listen accurately to what the students are saying and reflect it back to them, helping them focus on immediate, concrete goals or a plan of action. Sometimes a referral to a health or mental health provider may be important.

During the assessment process or at intake, it might be helpful to ask students what they would like staff to do if they were to become symptomatic or very anxious. In extreme cases, if persons appear to be a danger to themselves or others, the police should be called for assistance or a referral made to an emergency room. If staff are uncomfortable or feel in danger at any time in the presence of a student, the staff should remove themselves from the situation or get help immediately. Staff should respect and honor their own feelings as well as the student's and should act accordingly.

What it Means to Return to School

Returning to school is a very exhilarating and scary process for most people. Persons with a psychiatric disability are no exception. For most of them it dramatically changes how they feel about themselves and their potential for

having a meaningful and fulfilling life. Here are some examples from postsecondary students:

> *The Supported Education staff has high hopes for me and high expectations. They would like me to achieve a lot and it makes me feel good. I know that going to school will not give me all the guarantees in the world, but it gives me a glimmer of hope, and before, I had no hope whatsoever, and my vision of the future was all black. And just a little hope sometimes is all you need to get by.*

Spoken by a 29-year-old women diagnosed at age 16 with manic depressive illness. She is completing a paralegal certificate program at a community college.

> *So now I take my medicine. Now I have a job. I'm going to school. I don't want to be sick anymore. I want to be on the other end of the stick where I'm helping others instead of others always helping me. I want to be responsible.*

Spoken by a 39-year-old man, diagnosed as having paranoid schizophrenia, who has been in and out of hospitals and jails since he was 14. He has been involved in a supported education program for the past two years.

> *My kids tell me how different I am. I mean they have been trying to get me to go to school forever, and now they call me up and we talk about homework, and you know, it's like they're really proud of me that I'm doing this and getting on with my life.*

Spoken by a 47-year-old woman and recovering alcoholic who was sexually abused as a child, has suffered from severe depression, made numerous suicide attempts, and had many long periods of hospitalizations. She is now a peer counselor in a supported education program in addition to working on her academic studies.

> *I don't need school. I have V.A. comp and Social Security Disability but I don't want to be on the dole the rest of my life. So I've set my goal at a Masters of Social Work. But I can't overload myself. I came to school full-time a couple of semesters and the stress was just too much. I go back to having nightmares and flashbacks so I just come part-time. I'm chipping away at it slowly - but if I weren't here I would be dead or rotting in prison.*

Spoken by a 40-year-old Vietnam veteran diagnosed with Post Traumatic Stress Disorder and depression, who has a history of drug and alcohol abuse and violent behavior. With the assistance of a supported education program, he has completed his Drug and Alcohol Counseling Certificate and he is working on an AA Degree. He's active in many campus clubs, speaks at high schools about substance abuse and has toured major concert halls in the U.S. and foreign countries with a choral group.

Conclusion

Section 504 of the Rehabilitation Act of 1973 made it illegal for institutions receiving federal funds to discriminate on the basis of disability. However, people with psychiatric disabilities were often overlooked or ignored in the implementation of the act. It has taken changes in the fields of mental health, rehabilitation and education, as well as changes in the perceptions of the people themselves, to begin the process of more complete integration. The timely passage of the ADA further moved the process along. Today, with the emphasis on rehabilitation as a treatment modality, rather than simple caretaking and maintenance, and the development of new medications, most people with mental illness can look forward to a normal and productive life. Adult education is a important resource to help them make their dreams come true.

REFERENCES

Anthony, W.A., and Blanch, A. (1987). Supported education for persons who are psychiatrically disabled: An historical perspective. Psychosocial Rehabilitation Journal. 11(2), 5-23.

Barker, P.R., Manderscheid, R.W., Henderson, GE et al. Serious mental illness and disability in the adult household population: United States, (1989). Advance data from vital and health statistics: no 218, Hyattsville, MD: National Center for Handicapped.

Drake, R.E., Becker R.B., Biesanz, B.A. et al. (1994). Rehabilitative day treatment vs supported employment: I. vocational outcomes. Community Mental Health Journal. 30:5, 519-531.

Harding, C.M., Zahniser, J.H. (1994). Empirical correction of seven myths about schizophrenia with implications for treatment. Acta Psychiatr Scand. 90 suppl (384): 140-146.

Monahan, J. & Arnold, J. (1996). Violence by people with mental illness: a consensus statement by advocates and researchers. Psychiatric Rehabilitation Journal. 19:4, 67-70.

Partons, D. (1993). Implications of a systems approach to supported education at four California Community College model service sites. Psychosocial Journal. 17(1), 171-188.

Unger, K., Guest Editor (1993). Special Edition on Supported Education: Psychosocial Rehabilitation Journal, 17(1).

Unger, K. (1991). Serving students with psychiatric disabilities on campus: Clarifying the disabled student services counselor's role. Journal of Post-Secondary Education and Disability. 9(4), 278-281.

Unger, K., Anthony, W., Sciarappa, K., & Rogers, E. S. (1991). Development and evaluation of a supported education program for young adults with long-term mental illness. Hospital and Community Psychiatry, 42(8), 838-842.

Unger, K. (1990). Supported post secondary education for people with mental illness. American Rehabilitation, Summer, 10-14.

Unger, K., Danley, K., Kohn, L., & Hutchinson, D. (1987). Rehabilitation through education: A university-based continuing education program for young adults with psychiatric disabilities on a university campus. Psychosocial Rehabilitation Journal, X(3), 35 - 49.

QUESTIONS TO GUIDE PRACTICE

1. How would I solve the problem if the person had a physical disability?

2. What reasonable accommodations need to be made?

3. Is this an education or a treatment issue?

4. Do I need to make a referral to a community or campus resource?

5. Has there been a violation of the student code of conduct?

6. Am I working harder on this problem than the student who presented the problem?

REASONABLE ACCOMMODATIONS

- Assistance with registration/financial aid
- Extended time for exams
- Alternative format for exams
- Change of location for exams
- Alternate forms of completing assignments
- Notetaking help, tape recorders, books on tape
- Modified seating arrangements
- Allow beverages in class
- Parking
- Teach study skills
- Teach time management skills
- Incompletes rather than failures if relapse occurs

SPECIFIC NEEDS OF STUDENTS WITH PSYCHIATRIC DISABILITIES

Recruitment: The belief that education should be available to all. All people can learn new information and skills.

Participation: Encouragement and acceptance. An openness to individual styles of learning and being.

Retention: Provide accommodations, support, and when necessary, referrals.

MYTHS AND REALITIES

MYTH: People with mental illness are dangerous.

REALITY: They do not commit more crimes than the general population. They are more likely to be victims of crime.

MYTH: Mental illness is a chronic, lifelong disease.

REALITY: Prognosis for schizophrenia is 50 to 70 percent recovery. New medications make a normal life possible.

MYTHS AND REALITIES

MYTH: People with mental illness returning to school will disrupt the learning environment.

REALITY: They are not more disruptive than other students.

MYTH: Going to school is too stressful for people with mental illness.

REALITY: With new medication, symptom and stress management, and accommodations, they can be successful in school.

MYTHS AND REALITIES

MYTH: People with mental illness can only work in entry level positions.

REALITY: They can hold the same jobs as anyone. Accommodations may be necessary.

MYTH: People with mental illness cannot learn.

REALITY: Although they may have some learning problems, with accommodations they can reach their educational goals.

PRINCIPLES FOR PROVIDING SERVICES TO STUDENTS WITH PSYCHIATRIC DISABILITIES

1. Separate treatment issues from education issues.

2. Provide services to students with psychiatric disabilities as you would students with other disabilities.

3. Help students fulfill their behavioral responsibilities on campus.

FROM DISCRIMINATION TO ACCEPTANCE: SERVING PEOPLE WITH PSYCHIATRIC DISABILITIES IN ADULT EDUCATION

Response by Eloise Johnson

The paper gives an excellent perspective of how to understand the problems associated with adults with psychiatric disabilities. The information about a typical person who returns to school with psychiatric disabilities would be helpful for every Adult Basic Education (ABE) instructor. The individualized instruction that ABE classes provide can be a viable solution to serving this population.

The section that describes a typical person states that almost all are high school graduates. The adult education community does not solely focus on persons without a high school diploma. We offer GED preparatory instruction, but the focus goes way beyond that. Adults now, more than ever, need their basic skills upgraded to be able to survive in the workplace.

The concept of supported education has been used in our state for ABE students. The ABE programs at community colleges offer information about financial assistance, housing, career options, career assessments, and many other supportive resources. The financial assistance director will speak to the ABE class about how to fill out applications and discuss all procedures that are necessary to obtain assistance. Much internal stress can be alleviated by our classes offering an environment without internal and external stimuli distractions and assisting with social skills, taking tests, completing assignments on time, and managing time.

Adult education instructors in Mississippi have received intensive training in using a life skills curriculum. This curriculum is designed for individualized and group instruction. The basic skills for self-advocacy, self-determination, and acceptable social interactions can be incorporated into the personal identity of each ABE participant. The Lifeskills portion of each class day is one way to impart information in these areas; this segment of the day can also serve as a forum in which to utilize and practice the skills discussed in the sessions.

An ABE teacher's primary role in assisting adults with psychiatric disabilities will be as a liaison to provide a list of referral sources in the community; to know contact persons and sometimes to make an initial contact; to provide emotional support for an individual and a family; to aid career development planning; and to provide an ecological individual assessment.

The teacher is the key component that enables adult learners to feel successful in the classroom. Most successful instructors agree that the key to success is experimentation and trying various teaching/learning techniques until one finds strategies that work for a given individual. Techniques used in the classroom should include group learning and

projects, individual study, computer-assisted instruction, oral practice, written assignments, reading books, viewing video tapes, playing group games, listening to audio tapes, and maintaining a list of words that serve as a personal reference. Allowing for self-pacing in using and mastering materials enhances the academic self-concept and encourages people to become independent learners.

A strong academic and personal self-concept can be built through building a success identity. Role playing helps learn or improve social skills, self-concept, interactional skills, and work skills. Providing on-going group and personal counseling and support help to maintain the self-concept. If the learner knows that their specific needs will be accommodated in a class environment, it can increase the level of perseverance. Some of the instructional accommodations that may be needed are:

Extended time on test
Tutoring– peers or volunteers
Testing in separate room or quiet area
Tape record lessons
Computerized instruction
Extended time on written assignments
Using a notetaker for learners who have difficulty listening and taking notes
Giving a speech to instructor rather than class

Transition into the workforce is another point at which individuals with disabilities may require special assistance. One of the most important things a teacher can do is to model the appropriate way to speak about persons who have a disability. The ADA and other rehabilitation legislation mandate using the formula "person first, disability last" rather than using the disability as a descriptor. This pattern places the emphasis on the person rather than on the disability. The teacher who establishes this pattern in the minds of all learners will furnish all learners in the class with a valuable attitudinal shift.

The ABE teacher can prepare all adult learners for employment by incorporating job seeking skills into the curriculum and planned classroom activities. Acquiring job search skills is a learning process utilizing both individual and group practice. The development of a personal resume is one step in the process; practicing interview skills in a classroom context is another essential step.

Planning for transition for students means looking proactively into the future. It means defining the services a student will need in the future while simultaneously addressing the student's need to learn how to do things in the immediate present. The IEP can serve as a tool to help people attain personal skill development goals, knowledge of and purchase of assistive technology, and compensatory strategies needed throughout life.

Transition into the workforce or to further education is an important connection for all learners. Specific skills necessary for the job search, preparing for an interview, filling out application forms, appropriate dress, and other information will be covered using a Lifeskills curriculum. The ABE teacher can become a primary service provider for moving into the work force.

MYTHS

All of us are guilty of sharing in the myths that are discussed in the paper. Increased knowledge and experience about people with mental illnesses is of utmost importance. Our adult education instructors need training in beliefs and misconceptions.

Most people see mental illness as a chronic, lifelong disease. Instructors need to know that people with mental illnesses do not commit more crimes than the rest of the population. Only through conferences, workshops, and meetings can these important facts be presented.

With all the new medications and treatments available, people are managing mental illnesses better. All people need to feel useful and that they are contributing to society. Attending ABE classes or furthering their education anywhere will help raise self-esteem. Instructors need to have an awareness of the problem. Excessive stress on a person can be eliminated by a knowledgeable instructor and the individualized approach used in ABE.

ABE programs in our state work closely with business and industry to provide pre-employment and basic skills training. Through the IEP process each student sets individual goals. Working closely with industry allows the programs to talk with students about what the workplace expects and how to cope once employed.

With proper staff development about the myths that exist for adults with mental illnesses, instructors will be better prepared to offer the proper support and acclimate the adult to the campus environment. Developing a support network would be very beneficial. Peer support groups so people with common experiences can support each other exist on many of our campuses. Instructors must also have the total belief that all people are capable of learning and progressing. Workshops on the diverse learning styles is essential for instructors.

All principles and values that apply with an ABE class are the same necessary for working with students with psychiatric disabilities. The questions that are listed for adult education staff to ask themselves when they provide services are excellent. Training on conflict management and techniques for helping students manage their anxieties would be helpful. Instructors need to make certain on intake that they acquire all the necessary information about the student. Instructors need to be aware that their role is not counselor and should always maintain self-control, listen accurately to what

students are saying and help them focus on why they are there and their concrete goals or plan of action.

Adult education is a very important resource for persons with psychiatric disabilities. ABE programs can assist and support persons with psychiatric disabilities to be successful in achieving their educational goals. Instructors just need the proper training in order to assist these adults.

FROM DISCRIMINATION TO ACCEPTANCE: SERVING PEOPLE WITH PSYCHIATRIC DISABILITIES IN ADULT EDUCATION

Response by Muriel Lawler &
Bernadette Chavira-Merriman

Introduction

In Dr. Unger's paper "From Discrimination To Acceptance: Serving People With Psychiatric Disabilities In Adult Education" the basic premise suggested is that educational institutions were found guilty of discriminating against students with disabilities, but that gradually as institutions gained more experience working with people with mental illnesses, the transition became smoother.

The paper then attempts to explore myths and realities attached to people with mental illnesses. It further discusses how adult educators can assist and support these students, and closes with quotes which come from students and which focus on their perceptions regarding participation in the program.

The response to the paper will be arranged accordingly. A general response to the paper will be provided and a reaction to the premise will be expressed. Myths and realities will be discussed vis-a-vis students in the ABE classroom. Specific needs of students with psychiatric disabilities as they enter the postsecondary institution and ABE classes will be explored. Examples of teaching strategies, needs of adult learners, and best practices will be provided, and found in a companion document developed in New Mexico specific to adults with learning disabilities. The closing segment of the paper will consist of conclusions and recommendations.

Response

It is commendable that Dr. Unger is attempting to raise the consciousness of educators charged with providing services to students with disabilities. Perhaps for too long, these students have been ignored or neglected in postsecondary education, and their needs have most definitely not been met. However, a great number of these clients appear in Adult Basic Education (ABE) classes because they lack basic skills as well as higher order reasoning skills which they need in order to succeed. Another reason for their enrollment in ABE classes has to do with the institutional process itself. When there is doubt as to where the student should be placed, ABE tends to become a dumping ground. Once diagnostic testing has been accomplished, re-assignment into regular postsecondary classes may occur, but from comments made by local program people, we believe this does not often happen.

When reviewing the paper it became apparent that the document was written with a postsecondary institutional emphasis in mind, rather than an Adult Basic Education focus. The point needs to be made that Adult Basic Education

programs have been accepting students with mental disabilities and facilitating their learning as best they have been able to for years. Because our charge and chief responsibility is adults who need to acquire basic skills, because we are concerned that adults with disabilities receive the best possible treatment in our programs, and because we are hopeful that follow-up research will occur, we are responding from both historical and experiential points of view.

One of the main problems with the paper concerns the definition of terms. Frequently used terms such as "mentally ill," "mental disorders", "bi-polar", and "psychiatric disabilities" appear to be used interchangeably. The reader is confused about which specific population is being described and more to the point, which illness is being addressed. Consequently, adult basic educators may have the most honorable of intentions concerning assisting students, but will remain unclear as to how best serve these students without appropriate descriptors. It would have been most helpful if each population were described in detail, and if the thrust of the paper were focused on teaching practices specific to adults who appear to fit within those parameters. For example, "mental illness" (or any of the other terms used in the paper) should not be considered synonymous with lack of cognitive capacity. It could be inferred from the paper that this is the case.

Rather, these disabilities require extra effort on both the part of the student and the instructor in order for the student to benefit from instruction. Students suffering from these types of disabilities need assistance so that they can continue to function in both their real and scholastic worlds .

The ABE program has been accepting students with disabilities long before their cases were identified or before it became politically correct to do so. There just seemed to be no other niche in the postsecondary institutions; therefore, ABE provided services to students by employing best teaching practices and by urging the students to accept ownership of their particular disability. Adult Basic Education educators have always accommodated students to the degree possible without jeopardizing the program. In short, we have been providing these services, except that in today's vernacular these strategies would be known as "reasonable accommodations" or that the students would have an "ability to benefit."

While to some the process may have appeared to have been discriminatory against students with disabilities on the part of institutions, we would suggest rather that when the social climate changed regarding the care and housing of these individuals, federal programs at the national level were unprepared to assist states and local programs. Hence, the burden fell to postsecondary institutions, and to Adult Basic Education programs specifically. On numerous occasions, program people have called and requested specialized assistance in dealing with this population. Concerns were expressed about how to provide assistance, which strategies were effective, and how soon training could begin.

Eventually in New Mexico, the concerns raised were such that a work/study session was held at the annual conference which dealt with identifying the soft signs of a learning disabled adult.

Finally, a handbook was developed as a partial response and, quite frankly, as a stopgap measure. Therefore, while apparent discriminatory actions were occurring, remedies were being sought so that students could make progress in ABE. We would suggest that rather than overt discrimination, the real problem was due to ignorance and general lack of direction and assistance from the federal government.

Another problem contributing to the overall understanding of the paper is the apparent lack of specificity related to outcomes after students have availed themselves of services. For example, Dr. Unger states that a number of studies have shown that most people (50 to 70 percent) recover from schizophrenia (Harding, 1996). It is difficult to determine what "most" is and what the total "n" of the study consisted of before one can agree or disagree. Further, throughout the paper, terms such as "many", "few", and "some" are used as descriptors without specific citations, percentages, and what exact educational services were rendered to students, and what outcomes were a result of students participating in classes.

Myths and Realities About People with Mental Illness

Dr. Unger's contrast of myths and realities generally associated with mental illness patients is admirable in that it brings to the forefront fears which we, as educators, may harbor without full awareness. By raising the consciousness of administrators, practitioners, and other service providers, students with mental illness will be better served during their stay in ABE programs. However, we feel that the remedies suggested in the paper have traditionally been an integral part of meritorious ABE programs for some time.

For example, the myth surrounding these students purporting that going back to school would be too stressful for them, from the mental health provider and psychiatrists' perception, is counterbalanced by the reality. "With proper support and symptom management, people are able to take on the challenges of more meaningful activity." (Unger, 1996). Adult Basic Education educators have long known this strategy to be effective with ordinary students returning to attain basic skills. These students often come from chaotic backgrounds, stressful lifestyles and have familial responsibilities which (if not handled in a thoughtful manner) can result in a student dropping out of the program. Therefore, adult educators are made mindful of the fact that the students may not be coming from an ideal setting or positive past learning experiences, and that teaching strategies must acknowledge the same while also providing a venue for these students to experience success.

There has been a saying about Adult Basic Education students: "They vote with their feet." Loosely translated, if their needs are not met, they will not

participate in class. The same principles apply to students with mental illnesses– if their needs are not met, they will not participate.

Specific Needs of Students with Psychiatric Disabilities

Recruitment, participation and retention have been called the "big three" in Adult Basic Education jargon. They are inextricably intertwined and either work together to produce favorable results for the student, or the student withdraws. We do not see notable differences between Adult Basic Education students and those with mental illnesses in the matter of recruitment. Quite often there is a stigma attached to being an adult without basic skills. That is why in New Mexico 83% of the ABE programs are located in postsecondary institutions. Students can simply say, "I'm going to the college for classes." Once they transition from ABE to regular classes, the same statement is accurate.

Participation presents problems to the ABE student. They may have suffered from a negative past school experience; they are returning to unfamiliar surroundings; they suffer from anxiety because they know that someone will have to know their skill level in order to assist them through the system. ABE educators are extraordinarily empathetic and work hard at putting these students at ease. Students with a mental illness are to be treated no differently, except for perhaps an even more enhanced version of what "regular" students experience.

In the area of accommodations, educators will use excellent or best teaching practices. Students will always be accommodated to the degree possible without jeopardizing the program. The practice of reasonably accommodating students is not a new practice in the ABE classroom.

Conclusions/Recommendations:

While it is true that people with a variety of psychiatric disabilities have been overlooked in the past, we suggest that it was not overt discrimination, but lack of direction, funding, and training which could have been provided by the federal government to postsecondary institutions in order to remedy the situation. We have made the case that ABE administrators and instructors have traditionally accepted students as they were and worked with them and with their support system in order to provide services.

Based on the review of Dr. Unger's paper and our own experience we are recommending the following:

1) A definition of terms describing various mental illnesses and the accompanying manifestations which students may display.

2) Teaching strategies designed specifically to parallel those manifestations which will prove effective in the Adult Basic Education classroom.

3) A longitudinal study which will look at the outcomes of implementing such activities in the classroom.

4) Develop an enhanced accommodation model for students with mental illness which recognizes that cognitive ability is not necessarily synonymous with severe emotional disturbance.